

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 4 hours have passed, the certificate may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04482

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge,		b. COUNTY Dorchester Co.	
c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		d. STREET ADDRESS Hoopersville, Md.	
3. NAME OF DECEASED (Type or print) John Palmer Ashton		4. DATE OF DEATH April 10, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1983	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Hoopersville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Ashton		14. MOTHER'S MAIDEN NAME Sarah Wroton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT 215-18-4958 Mrs. John Ashton Address Hoopersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 610		INTERVAL BETWEEN ONSET AND DEATH 2 mos. Benzene - Anemia Benzene Prostatic Hypertrophy yes.	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from.... 10-30, 1961, to 4-10, 1962, that (I) (we) last saw the deceased alive on.... 4-9, 1962 and that death occurred at 4:30 AM from the causes and on the date stated above.		22b. DATE SIGNED 4-11-62	
22a. SIGNATURE J.W. Barnard M.D.		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 12, 1962	
23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		23d. LOCATION (City, town or county) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Tissue	
DATE APR 24 '62			

последователь

последователь

последователь

последователь

1860



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05749

Reg. Dist. No.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Hubbard Street				d. STREET ADDRESS 7 Hubbard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First	Middle	Lost	4. DATE OF DEATH April 28	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 15, 1879	9. AGE (In years lost birthday) 83 yrs.	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS. Days	13. IF OVER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George R. Banks		14. MOTHER'S MAIDEN NAME Mary Jackson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-8198		17. INFORMANT Lillie Fisher, Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Generalized Arteriosclerosis (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <u>Feb 1, 1961</u> to <u>April 28, 1962</u> , that I last saw the deceased alive on <u>April 28, 1962</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 227 Pine St., Cambridge, Md.		
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>						DATE SIGNED 4-30-62		
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1962		22c. NAME OF CEMETERY OR CREMATORIAL East New Market		22d. LOCATION (City, town, or county) Dorchester County, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Clark Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAY 23 '62		24b. REGISTRAR'S SIGNATURE <i>Albert S. Krause</i>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

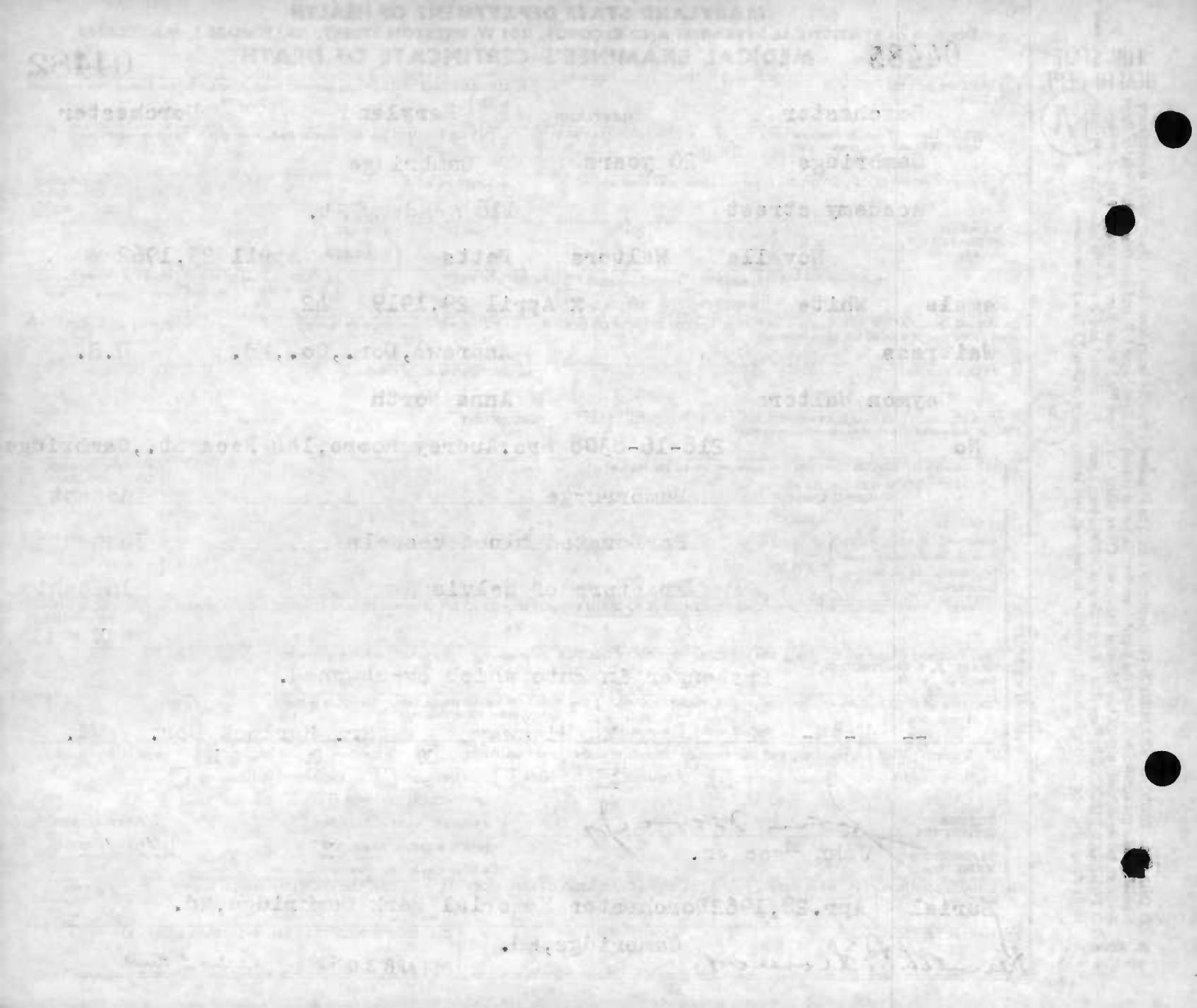
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04485

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04482

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residencia before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Academy street		e. STREET ADDRESS 116 Academy St.	
3. NAME OF DECEASED (Type or print) Novella Walters		4. DATE OF DEATH April 25, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH April 29, 1919	
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
11. BIRTHPLACE (State or foreign country) Andrews, Dor., Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daymon Walters		14. MOTHER'S MAIDEN NAME Anna North	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-8308	
17. INFORMANT Mrs. Audrey Moore, 144 Race St., Cambridge		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 822 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Perforated blood vessels DUE TO (b) Fracture of pelvis DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES		20. TIME OF INJURY Month, Day, Year Hour a.m. 4 am 1-25-1962	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE THEREOF Apr. 28, 1962	
23. FUNERAL DIRECTOR Kenneth P. Sheppard		24. ADDRESS Cambridge, Md.	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial		26. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park	
27. LOCATION (City, town, or country) Cambridge, Md.		28. REC'D BY REGISTRAR DATE APR 30 '62	
29. IS RESIDENCE ON A FARM? YES		30. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04486

04483

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

OFICIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN b. 2 years 10m. 1w.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rhodesdale	
3. NAME OF DECEASED (Type or print) SARA		First Ann	Middle BREUIL
3. NAME OF DECEASED (Type or print) SARA		Last BREUIL	4. DATE OF DEATH 4 Month 4 Day 19 62
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-88
9. AGE (In years last birthday) 74 yrs.		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0 Dey 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	10. IF UNDER 24 HRS. Hours 0 Min. 0
13. FATHER'S NAME William James Scott		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or grade of service)		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1		20. DUE TO Generalized arteriosclerosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		21. DUE TO Cancer of Gallbladder	
} (c)		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Cambridge		(County) Md.	
(State) Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 59 , to 4-4 , 19 62 , that (I) (we) last saw the deceased alive on 4-3 , 19 62 , and that death occurred at 125 M, from the causes and on the date stated above.		22b. DATE SIGNED 4-4-62	
22c. SIGNATURE Jacob Morgenstern		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) JACOB MORGESTERN		22d. ADDRESS Eastern Shore State Hosp. Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/6/67		23b. DATE THEREOF 4/6/67	23c. NAME OF CEMETERY OR CREMATORIAL Family St
24. FUNERAL DIRECTOR'S SIGNATURE Willie Hollingsby, East New Market, Md.		ADDRESS 100 Main St, East New Market, Md.	25a. REC'D BY REGISTRAR DATE APR 9 '62
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

38840

37-392-10 STALWITZ

28510

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04487

CERTIFICATE OF DEATH

04484

M

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

Since 11-18-58

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

John

Bunchko

4. DATE
OF
DEATH

April

27

1962

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

1876

86

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Laborer (?)

Germany

Germany (?)

13. FATHER'S NAME

John Bunchko

Elizabeth (Maiden name unknown)

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

182-20-4768 Eastern Shore State Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

491X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-1-1961 to 4-27-1962, that (I) (we) last saw the deceased alive on 4-27-1962, and that death occurred at 8 a.m. from the causes and on the date stated above.

22e. SIGNATURE

Houston G. Foster

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED

4-27-62

22c. PHYSICIAN'S
NAME (Type)

Houston G. Foster

22d. ADDRESS

E.S.S. Hospital, Cambridge, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR Crematory

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

DATE MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Arlene S. Trahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

21 22 23 24

11

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04485

TO DEATH EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certifier, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

4 HRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Maryland Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Last

4. DATE
OF
DEATH

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

C

WIDOWED

DIVORCED

July 4, 1880

81 yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Richard Camper

Hester Pinkett

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

Mrs. Walter McGrath

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Reptured Thoracic aneurysm 4 hrs

022X DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
(c)

INTERVAL BETWEEN
ONSET AND DEATH

2
MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Alfred R. Maryland

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

ALFRED R. MARYANOV

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

136 RACE ST 4/5/62
CAMBRIDGE MD

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

23. FUNERAL DIRECTORY

4/7/62

ADDRESS
East New Market

East New Market, Maryland

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE APR 11 '62

Arthur S. Kline

22110

22110

M

I

X

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1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04489 MARYLAND STATE DEPARTMENT OF HEALTH
PRINTER OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04486

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

3 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

20 Center Street

3. NAME OF
DECEASED
(Type or print)

First
Luther

Middle

Last
Collins

4. DATE
OF
DEATH

Month
April

Day
8

Year
19 62

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

About 1889

9. AGE (in years
last birthday)

About 73

IF UNDER 1 YEAR

Months
Days

IF UNDER 24 HRS.

Hours
Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Dorchester Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Collins

14. MOTHER'S MAIDEN NAME

Nancy Neal

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

220-12-1214

17. INFORMANT

Thelma Collins Layer, Cambridge, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH
?

782-4 DUE TO

Conditions, if any, which
give rise to immediate cause

(b)

(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Dr. John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4/9/62

Address (Street, city, town, or county) Cambridge, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 11, 1962

22c. NAME OF CEMETERY OR CREMATORIUM

Federal Hill Cemetery

22d. LOCATION (City, town, or country)

Federalsburg, Maryland

(State)

23. FUNERAL DIRECTOR

ADDRESS

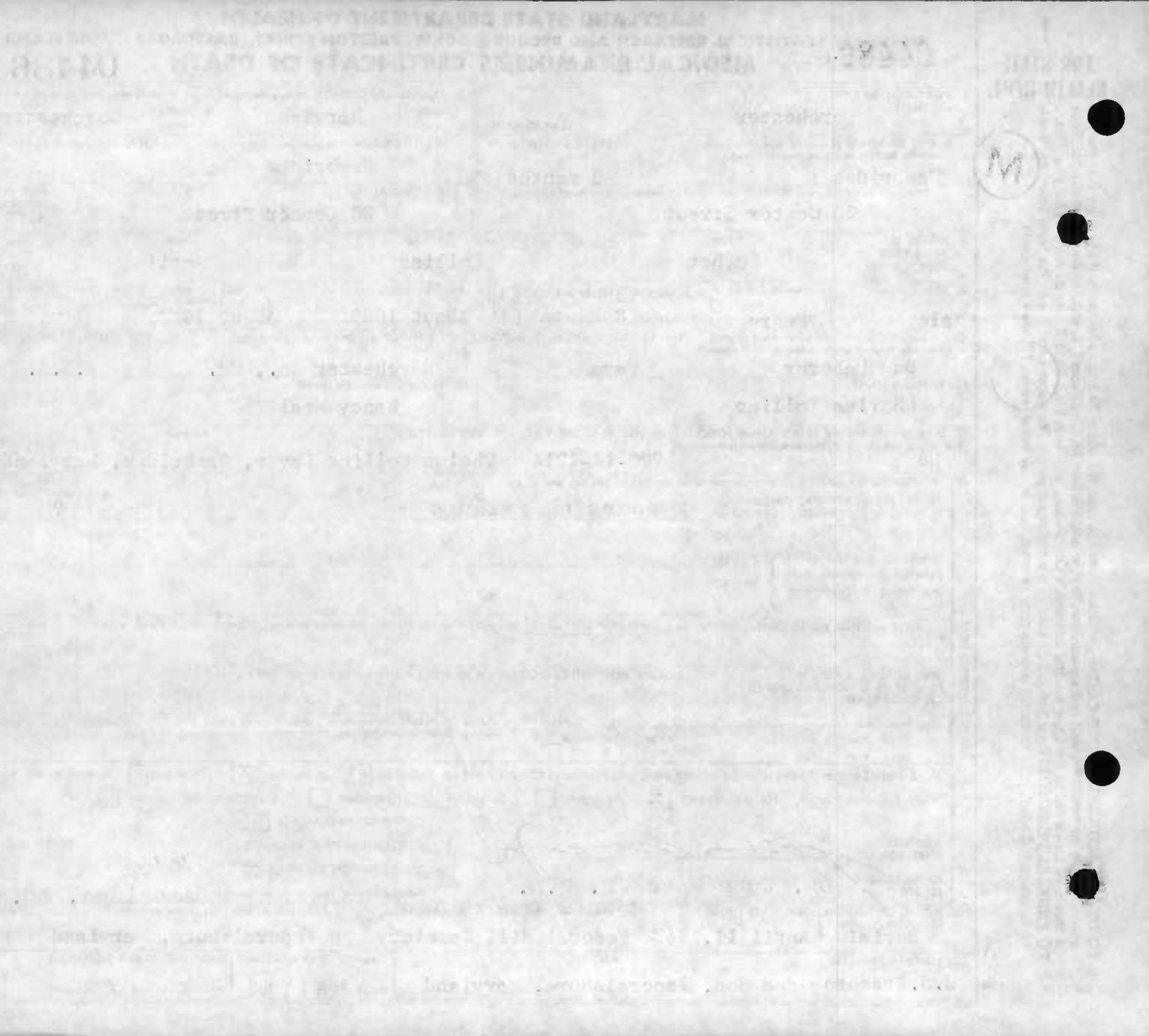
J.J. Frampton and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR

DATE APR 11 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

M

04490

CERTIFICATE OF DEATH

Reg. Dist. No.

04487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. If institution, residence before admission, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 3 Park Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Outtie	Middle Eldridge	Last Cornish	4. DATE OF DEATH April 23, 1962	Month April	Day 23	Year 1962
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1910	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months 51	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Yard Work		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Cornish				14. MOTHER'S MAIDEN NAME Emma J. Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-2613		17. INFORMANT Marion Cornish, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF ESOPHAGEAL VARIX DUE TO 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF LIVER DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/22 , 1962, to 4/23 , 1962, that I last saw the deceased alive on 4/22 , 1962, and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 RACE ST DATE SIGNED 4/30/62							
ACTUAL SIGNATURE Alfred R. Maryanov M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/25/1962 22c. NAME OF CEMETERY OR CREMATORIAL Beckwith Cemetery 22d. LOCATION (City, town, or county) Dorchester County, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Richard M. McCloskey		24a. REC'D BY REGISTRAR DATE MAY 7 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Traas					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04491

04488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Golden Hill, Maryland

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Golden Hill, Md.

3. NAME OF DECEASED
(Type or print)

Grace

Gootee

Cusick

4. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

7. MARRIED

 NEVER MARRIED

WIDOWED

 DIVORCED

13. FATHER'S NAME

A. Festus Gootee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mr. Edgar C. Cusick

Address

Golden Hill, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

443 X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cerebrovascular Accident

Hypertensive CVD

INTERVAL BETWEEN
ONSET AND DEATH

2 hr

10 yrs.

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-16-1964, to 4-22-1964, that (I) (we) last saw the deceased alive on 4-22-1964, and that death occurred at 5 A.M., from the causes and on the date stated above.

22a. SIGNATURE

M. Bannister

M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 24, 1962

23c. NAME OF CEMETERY OR CREMATORIAL

Dorchester Mem. Park

23d. LOCATION (City, town or county) (State)

Cambridge, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

Cambridge, Md.

25a. REC'D BY REGISTRAR

MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. If 24 hours may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04492

CERTIFICATE OF DEATH

04489

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <i>Dorchester</i>		a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		b. COUNTY <i>Kent</i>	
c. LENGTH OF STAY IN 1b <i>4 yrs - 11 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Worton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eastern Shore State Hospital</i>		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <i>William James Dempsey</i>		4. DATE OF DEATH <i>April 18 1962</i>	Month Day Year
First <i>William</i>	Middle <i>James</i>	Last <i>Dempsey</i>	Month <i>April</i> Day <i>18</i> Year <i>1962</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM OWNER</i>	9. AGE (In years last birthday) <i>73 yrs.</i>
10c. FATHER'S NAME <i>Edward Dempsey</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kent Co., MD.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. MOTHER'S MAIDEN NAME <i>Rose Overton</i>		14. INFORMANT <i>Pt's. Medical Record - Hospital</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Pt's. Medical Record - Hospital</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i>		Address <i>Unknown</i>	
(b) <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Still Pond, MD.</i>
20f. (City or town) <i>Still Pond, MD.</i>		(County) <i>Still Pond, MD.</i>	
(State) <i>MD.</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1957</i> to <i>April 18, 1962</i> that (I) (we) last saw the deceased alive on <i>April 18, 1962</i> and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.			
22e. SIGNATURE <i>Houston G. Foster</i>		22b. DATE SIGNED <i>4-18-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOUSTON G. FOSTER</i>		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4-26-62</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>STILL POND CEMTY</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>		ADDRESS <i>STILL POND, MD.</i>	25a. REC'D BY REGISTRAR DATE <i>APR 19 '62</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

СКРИ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04493

CERTIFICATE OF DEATH

04490

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

D.C.A.

c. LENGTH OF STAY IN 1b

Cambridge

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Md. Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Francis H. Hubbert

5. SEX

6. COLOR OR RACE

male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired farmer

10b. KIND OF BUSINESS OR INDUSTRY

same

13. FATHER'S NAME

Henry Hubbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

220-12-1145A

14. MOTHER'S MAIDEN NAME

Mary Jane Gambrill

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO
cause last.

(c)

acute myocardial infarction 5 1/2 hr.

arteriosclerotic heart disease 5 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 19
p.m.

20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 30, 1960 to April 5, 1962, that (I) (we) last
saw the deceased alive on April 5, 1962, and that death occurred at 5:55 AM, from the causes and on the date stated above.

22e. SIGNATURE

Jason F. G. Yee, M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22f. DATE
SIGNED

4-6-62

22c. PHYSICIAN'S
NAME (Type)

JASON F. G. YEE, M.D.

22d. ADDRESS

Hurlock Medical Center, Hurlock, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

burial

23b. DATE THEREOF

4/8/62

23c. NAME OF CEMETERY OR CREMATORIAL

Hillcrest Cemetery

23d. LOCATION (City, town or county)

Federalsburg, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Anna Williams

ADDRESS

Federalsburg, Md.

25a. REC'D BY REGISTRAR

DATE APR 10 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

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MEDICAL CERTIFICATION

VR A15 (4)
15M 7/61

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04494

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04491

TO DEFENDERS OF LIFE: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
3. NAME OF DECEASED (Type or print) Sarah Waters		d. STREET ADDRESS 145 Washington St.	
3. NAME OF DECEASED (Type or print) Sarah Waters	First Last	Middle Jenkins	4. DATE OF DEATH April 26, 1962 Month Day Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1898 9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wlibur Waters		14. MOTHER'S MAIDEN NAME Gracie Camper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alfred Jenkins, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b)		Cerebral vascular accident DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Dr. John Mace Jr. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/62	
22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery		22d. LOCATION (City, town, or country) (State) Cambridge, Dor. Md.	
23. FUNERAL DIRECTOR Herbert St Clair		ADDRESS Cambridge, Md.	
24e. REC'D BY REGISTRAR MAY 7 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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Washington, D. C.

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SCI 100

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canal stenosis

basal cell

cataract

cataract

cataract

cataract lens

cataract lens cell stain

Side

0.5 mg

total

0.5

ml

10

0.005 ml x

ml

ml

AM

basal cell

basal cell

canal stain

canal stain

BC cataract lens cell stain

on

on

even 5

epithelial basal cell

epithelial basal cell

even 10

x

x 50

0.5 mg

Do

0.5 ml

ml

ml

ml

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cataract lens cell stain

cataract lens cell

cataract lens

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FOR STATE
HEALTH DEPT.

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04496

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04493

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge R. F. D.

c. LENGTH OF STAY IN lb

2 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

EASTERN SHORE STATE HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

STEPHEN

Middle

Last

JAMES

LECATES

Month

7

Dey Year

1962

4. SEX

6. COLOR OR RACE

M

7. MARRIED NEVER MARRIED

W

WIDOWED DIVORCED

4. DATE
OF
DEATH

90 Yrs

90

(1871)

90

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Introduktion till den svenska

1992-1993



FOR STATE
HEALTH DEPT.

TO DIRECTOR, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04494

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residencia before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital, Cambridge, Md			
3. NAME OF DECEASED (Type or print) Alonzo		4. DATE OF DEATH Month Day Year April 27th 1962	
First Middle ---		Last Lewis	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/1890	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. AGE (In years 1st birthday) 71 yrs.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (Laborer)		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown Revelle Lewis			
14. MOTHER'S MAIDEN NAME Abby/Abigail Mary Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) Unknown Yes WW 1		16. SOCIAL SECURITY NO. 217-01-4613	
17. INFORMANT Medical Records, Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 936.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures of ribs DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
16 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Knocked down by another mental patient.	
20c. TIME OF INJURY Month, Day, Year Hour e.m. ? 4-11-62 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Cambridge	
(County) Dor.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>			
EXAMINER'S NAME (Type) John Mace Jr.			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/62	
22c. NAME OF CEMETERY OR CREMATORIUM American Legion Cemetery		22d. LOCATION (City, town, or country) Crisfield, Maryland	
(State)			
23. FUNERAL DIRECTOR Brookshaw & Sons.		ADDRESS <i>Georgetown Md.</i>	
24a. REC'D BY REGISTRAR MAY 3 '62		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	
DATE SIGNED 4/28/62			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
may be reviewed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04498

Item 2 Film G312

5/7/62 iwk

04495

1. PLACE OF DEATH o. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY DORCHESTER				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 1/2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 RURAL - PHILADELPHIA		d. STREET ADDRESS 4747 Westland Blvd.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) BESSIE		First BESSIE	Middle MAY	Lost LEWIS	4. DATE OF DEATH APRIL 26 1962	Month APRIL	Day 26	Year 1962		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/90		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME BEN FRANK TRAVERS			14. MOTHER'S MAIDEN NAME LOUISE PARKER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-0373		17. INFORMANT HOSP. RECORDS, ESSH, CAMBRIDGE, MD.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 7 DAYS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ARTERIOSCLEROSIS		(b) DUE TO		(c)		UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) RFD 2, CAMBRIDGE, MD.	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from JAN. 10 1962 to APRIL 26 1962 , that (I) (we) last saw the deceased alive on APRIL 25 1962 , and that death occurred at 6 A.M. from the causes and on the date stated above.						22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) GEORGE H. LONGLEY		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
22d. ADDRESS RFD 2, CAMBRIDGE, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 28 Apr 162	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glen Haven Mem. Park		23d. LOCATION (City, town, or county) Glen Burnie		(State) Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		ADDRESS Glen Burnie		25a. REC'D BY REGISTRAR Arthur S. Kline		25b. REGISTRAR'S SIGNATURE				
				DATE MAY 1 '62						

18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04496

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 35 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fishing Creek, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital Inc.		d. STREET ADDRESS I Fishing Creek, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Jill	Middle Robin	Last Lewis	4. DATE OF DEATH April	Month April	Day 11	Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4-10-62	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 11	Hours Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Riley Lewis				14. MOTHER'S MAIDEN NAME Lois Marie Hughes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Lois Lewis - Fishing Creek, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline membrane disease DUE TO 773.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 411162	(County) 411162	(State) 411162
21. I certify that I attended the deceased from 4/10/62 , to 4/11/62 , that I last saw the deceased alive on 4/11/62 , and that death occurred at 700 p.m. , from the causes and on the date stated above.								
ACTUAL SIGNATURE Lawrence Maryanov M.D.								
PHYSICIAN'S NAME (Type) Lawrence Maryanov Cambridge, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13, 1962		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service ADDRESS Cambridge, Md.								
VS A15 (4) 15M 9/55				24a. REC'D BY REGISTRAR DATE APR 19 '62				
				24b. REGISTRAR'S SIGNATURE Lawrence Maryanov				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours have not passed, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04500

CERTIFICATE OF DEATH

04497

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

Since 3-30-62

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

JOHN

First

Middle

Last

MARTIN

4. DATE
OF
DEATH

April 24 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

3/17/79

9. AGE (In years
last birthday)

83 ? yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10b. KIND OF BUSINESS OR INDUSTRY

Machinist Goodyear Rub.
Co.

11. BIRTHPLACE (County & State, or foreign country)

Unknown Switzerland

12. CITIZEN OF WHAT COUNTRY?

USA

Naturalize

13. FATHER'S NAME

Unknown

Fidel Marton

14. MOTHER'S MAIDEN NAME

Unknown

Louise Medler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

290-10-3495

17. INFORMANT

Address

Eastern Shore State Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACUTE MYOCARDIAL INFARCTION

INTERVAL BETWEEN
ONSET AND DEATH
ONE MINUTE

IMMEDIATE CAUSE (a)

EX-10

STAGE 10 GRADE 10

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04501

CERTIFICATE OF DEATH

04498

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. If 24 hours may be required by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN b

25 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

207 Crusader Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Evelyn

4. SEX
Female

White

5. COLOR OR RACE
10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sewing Factory Seamstress

6. MARRIED NEVER MARRIED
WIDOWED DIVORCED 7. DATE OF BIRTH
8. DATE OF BIRTH

July 8, 1904

11. BIRTHPLACE (County & State, or foreign country)

Caroline County, Md.

4. DATE
OF
DEATH
April 27, 1962

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. STREET ADDRESS
1 207 Crusader Road14. IS RESIDENCE
ON A FARM?
YES NO

15. FATHER'S NAME

Harrison Mears

14. MOTHER'S MAIDEN NAME

Nannie Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-07-7489 Mrs. Schuyler Raymond, 207 Crusader Rd.,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

171X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

METASTASIS FROM CARCINOMA OF CERVIX

INTERVAL BETWEEN
ONSET AND DEATH

10 mos

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

DIABETES MELLITUS

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 6/5 1961 to 4/27 1962, that (I) (we) last
saw the deceased alive on 4/27 1962, and that death occurred at 11:40 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Alfred R. Maryanov

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
4/28/6222c. PHYSICIAN'S
NAME (Type)

ALFRED R. MARYANOV

22d. ADDRESS

136 RACE ST CAMBRIDGE, MD

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL
Spring Hill Cemetery Easton, Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Kenneth R. Shuman

ADDRESS

Cambridge, Md.

25e. REC'D. BY REGISTRAR

APR 30 '62

DATE

25f. REGISTRAR'S SIGNATURE

Cirrus S. Thorne

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04502

04499

CERTIFICATE OF DEATH

Item 23b Film G313 5/17/62 m

1. PLACE OF DEATH
a. COUNTY

DORCHESTER

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL - CAMBRIDGE

29 YRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

EASTERN SHORE STATE HOSP.

3. NAME OF
DECEASED
(Type or print)

ELVIRA YLONEN PURO

First

Middle

Last

4. DATE
OF
DEATH

APRIL 23

1962

5. SEX

F

WHITE

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

11/20/79

9. AGE (in years
last birthday)

82 yrs.

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

FINLAND

12. CITIZEN OF WHAT COUNTRY

FINLAND

13. FATHER'S NAME

JEREMIAH YLONEN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

HOSP. RECORDS, ESSH.

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)4200
DUE TO

ARTERIOSCLEROTIC HEART DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

20 YRS

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

PERNICIOUS ANEMIA

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
White
at work Not White
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JAN 5, 1962, to APRIL 23, 1962, that (I) (we) last
saw the deceased alive on APRIL 21, 1962, and that death occurred at 6 A.M., from the causes and on the date stated above.

22a. SIGNATURE

George H. Longley

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

GEORGE H. LONGLEY

22d. ADDRESS

Rt. 2, Cambridge, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 25, 1962

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

North East, Cecil, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Joseph R. Graut

ADDRESS

25a. REC'D BY REGISTRAR

DATE APR 27 '62

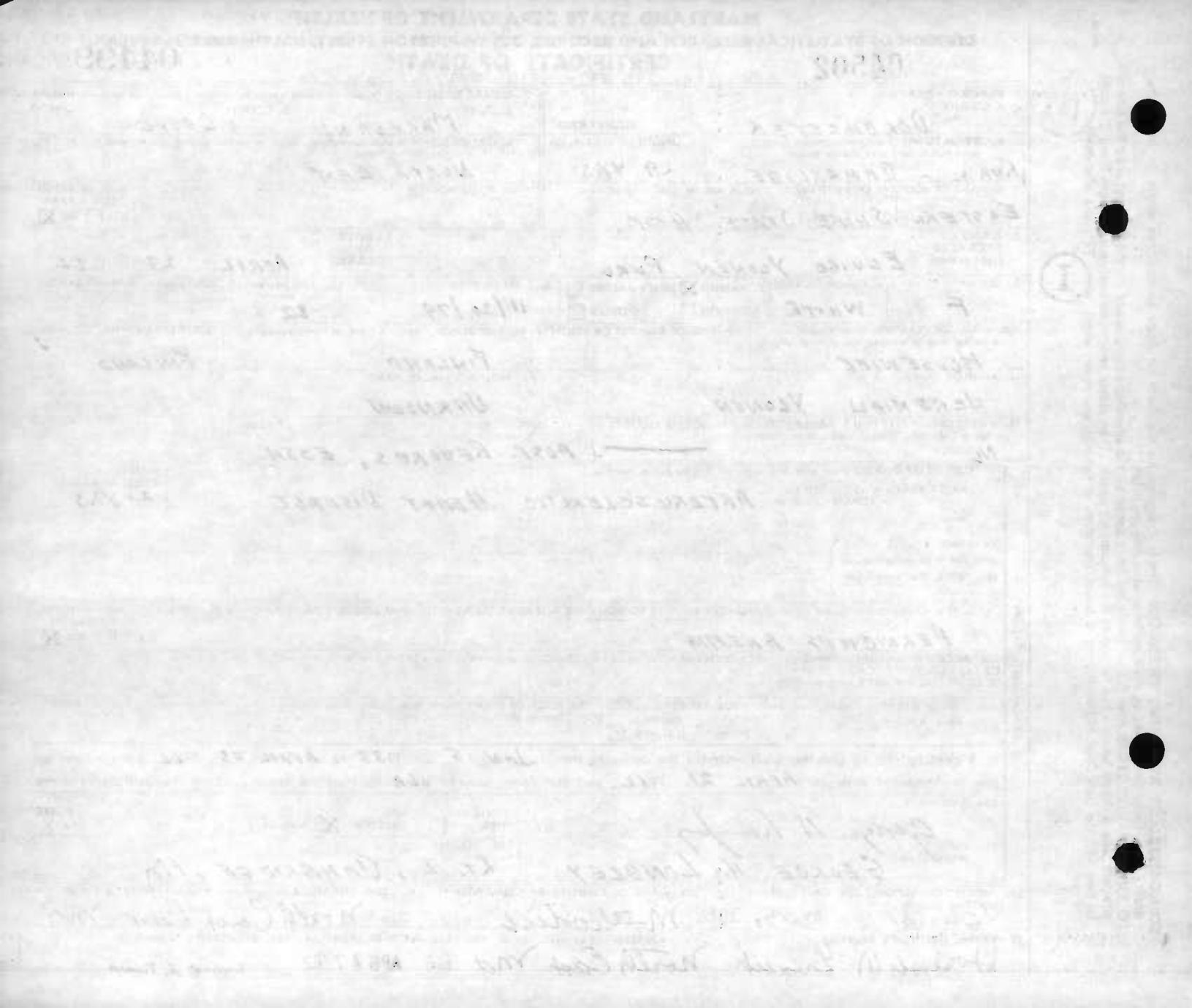
25b. REGISTRAR'S SIGNATURE

John S. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours have not passed, the certificate should be signed by the attending physician. After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 4 Film G-314 6/4/62 11/26/62

04503 **04500**

1. PLACE OF DEATH a. COUNTY		Items 2 & 17, Film G-314 6/4/62		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
Dorchester Co. MARYLAND		6/4/62		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Cambridge, Md.		2 $\frac{1}{2}$ Years		Dorchester Co.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge Md. Hospital				Secretary, Md. X Cambridge	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Helen K. Shaffer					April Month Day Year
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 15, 1902	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
None		None		59 yrs.	
10. IF UNDER 1 YEAR Months Days		11. BIRTHPLACE (County & State, or foreign country)		12. IF UNDER 24 HRS. Hours Min.	
		Secretary, Md.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		U.S.A.	
Joseph Koski		Elizabeth Mitchell		Address 840 N. Eutaw St., Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Joseph E. Mr. James Shaffer Secretary, Md. Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized carcinomatosis			
15+X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Recurrent adenocarcinoma of rectum			
DUE TO (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
DUE TO (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1 1959</u> to <u>Mar 31 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 31 1962</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <i>Lewis M. Burdette</i>		22b. DATE SIGNED Apr 3, 1962			
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 4, 1962		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	
24 FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR APR 10 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

00000

1
FOR STATE
HEALTH DEPT.



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04504

04501

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

since 11-4-59

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

First: Harvey

Middle: RUSSELL

Last: Sturgis

4. DATE
OF
DEATH

April

18

19 62

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

7-17-92

9. AGE (In years
last birthday)

69
yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

Male

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Grocerman

10b. KIND OF BUSINESS OR INDUSTRY

- Grocery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levin Sturgis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

218-20-5370

INFORMANT
Mrs. Pauline E. Disharoon (Daughter) 207 E.
Eastern Shore State Hospital records College
Salisbury, Maryland
ONSET AND DEATH
10 Min.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary thrombosis

420
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

N/A

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

N/A

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

N/A

20f. (City or town)

N/A

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John Mace Jr. Cambridge, Md.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4/18/62

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Apr. 21, 1962

22c. NAME OF CEMETERY OR CREMATORIUM

Parsons Cemetery

22d. LOCATION (City, town, or country)

Salisbury, Maryland

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

VS. A15ME
5M 9/60

HOLLOWAY & COMPANY

SALISBURY, MARYLAND

DATE APR 23 '62

Arthur S. Mace

11610

11611

volcan

volcan

volcan

volcan

volcan

volcan

volcan

volcan

31

volcan

26\31\

1

volcan

volcan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04505

05778

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Toddville, Md.

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Toddville, Md.

3. NAME OF DECEASED (Type or print)

First
Erma

Middle
Frances

Last
Todd

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED
 WIDOWED
 DIVORCED

8. DATE OF BIRTH

April 16, 1897

9. AGE (In years last birthday)

65
yrs.

IF UNDER 1 YEAR
Months
Days

IF UNDER 24 HRS.
Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Toddville, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Artillus Todd

Jevenia Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Hiram Todd

Address

Toddville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

171X

DUE TO

(b)

DUE TO

(c)

*carcinoma cervix
with metastasis*

INTERVAL BETWEEN ONSET AND DEATH

8 years

19. WAS AUTOPSY PERFORMED? YES NO

0

20a. ACCIDENT WAS UNDERLYING OP. CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour
e.m.
p.m.

Month
19

Day
at work at work

20d. INJURY OCCURRED

While
Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11/10/1961 to 4/22/1962, that (I) (we) last saw the deceased alive on 4/22/1962 and that death occurred at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE

J. B. Barnes

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE SIGNED

5/12/62

22d. ADDRESS

Cambridge 6 - Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23c. NAME OF CEMETERY OR CREMATORIAL

April 24, 1962

Zion Church

23d. LOCATION (City, town or county)

Toddville,

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

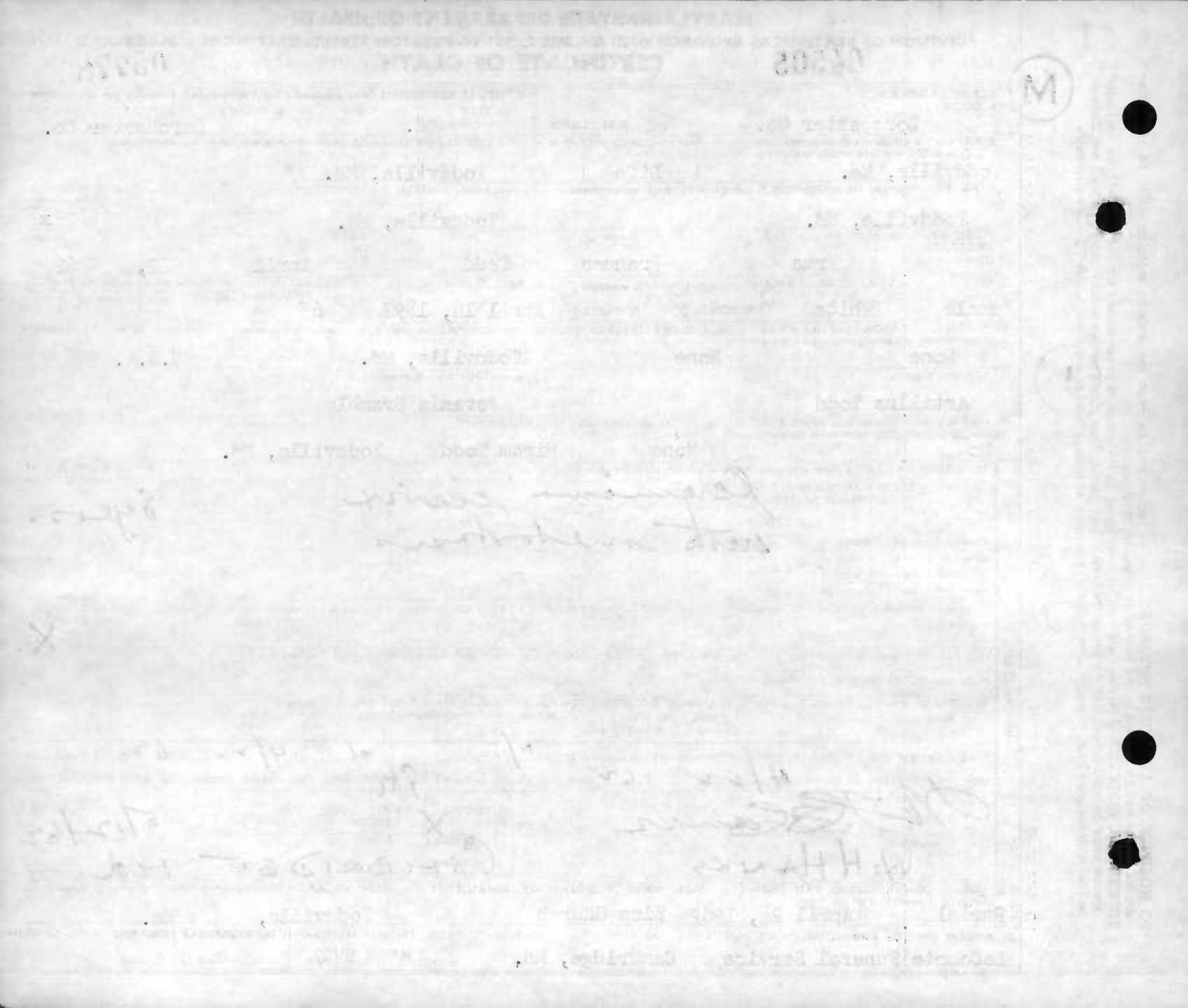
Cambridge, Md.

25a. REC'D BY REGISTRAR

MAY 16 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04506

CERTIFICATE OF DEATH

04502

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

3 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

George

John Watts

Last

4. DATE OF DEATH

Month

Day

Year

April

2029-2

b. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

June 3, 1879

9. AGE (In years
last birthday)

82 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown CARPENTER & CANNING IND.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Talbot Co.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Sinclair Watts

14. MOTHER'S MAIDEN NAME

Unknown ELIZABETH LOFTLAND

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (Hyas give rank or dates of service)

No

16. SOCIAL SECURITY NO.

220-09-738

17. INFORMANT

Unknown

Hospital Records Cambridge, Ind.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4200

Arteriosclerotic Heart

Disease

Unk

DUE TO

Conditions, if any, which
gave rise to immediate cause

(b)

(a), stating the underlying
cause last.

DUE TO

(c)

3022

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04507

CERTIFICATE OF DEATH

04504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be attended by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

67

M

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

c. LENGTH OF STAY IN 1b

45 Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Md. Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Maggie

Evelene

Willey

4. DATE OF DEATH

Month

Day

Year

April

11,

19 62

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

B. DATE OF BIRTH

Jan. 1882

9. AGE (In years last birthday)

80 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Andrews, Md. (Dorchester Co.) U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Riley Hughes

Marjorie Hughes

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Omro Willey

715 Race St. Cambridge, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Due to (b)
Due to (c)

Myocardial Infarction

Coronary Heart Disease

Diabetes Mellitus

INTERVAL BETWEEN
ONSET AND DEATH

4 days

3 yrs.

2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19

20d. INJURY OCCURRED
Whiles
at work Not Whiles
at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/17/62, 19....., to 4/11/62, 19....., that (I) (we) last saw the deceased alive on 4/11/62, 19....., and that death occurred at.....M, from the causes and on the date stated above.

22a. SIGNATURE

Lawrence Maryanov

M.D.

22b. DATE SIGNED
4/16/62

22c. PHYSICIAN'S NAME (Type)

Lawrence Maryanov

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 13, 1962

23c. NAME OF CEMETERY OR CREMATORIAL

Dorchester Mem. Park

23d. LOCATION (City, town or county)

(State)

Cambridge,

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

Cambridge, Md.

25a. REC'D BY REGISTRAR

APR 19 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

VR A15 (4)
15M 7/61

B6

10000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurred 24 hours or more after the physician or attending physician, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04508

CERTIFICATE OF DEATH

04505

1. PLACE OF DEATH

a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

c. LENGTH OF STAY IN 1b

15 Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Md. Hospital

3. NAME OF
DECEASED
(Type or print)

First
Ada

Middle
Brannock

Woolen

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

June 7, 1894

9. AGE (In years
last birthday)

67
yrs.

IF UNDER 1 YEAR

Months
Days

IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Madison, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Edward Brannock

14. MOTHER'S MAIDEN NAME

Margaret Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. John Woolen

Address

E. Appleby Ave. Camb. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

33IX

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Central Nervous System
Hypertension (severe)

INTERVAL BETWEEN
ONSET AND DEATH

3 days

0
MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. 19 at work at work

20d. INJURY OCCURRED
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

4/10 1962 to 4/24 1962

21. I certify that (I) (this hospital) attended the deceased from 4/10 1962 to 4/24 1962, and that death occurred at Cambridge, Md., from the causes and on the date stated above.

22e. SIGNATURE

W.H. Hanks
W.H. Hanks

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22f. ADDRESS

Cambridge, Md.

4/28/62
22b. DATE
SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 27, 1962

23c. NAME OF CEMETERY OR CREMATORY

Dorchester Mem. Park

23d. LOCATION (City, town or county)

Cambridge, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

LeCompte Funeral Service

ADDRESS

Cambridge, Md.

25a. REC'D BY REGISTRAR

MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

20010

МАССА СТАНДАРТ

M